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Substance abuse counselor's attitudes regarding lesbian, gay, bisexual, and transgendered clients

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Abstract

Purpose: The attitudes of substance abuse counselors can have significant effects on their client's recovery. This study examined the attitudes and knowledge of substance abuse counselors regarding lesbian, gay, bisexual, and transgendered (LGBT) clients. **Methods:** 242 substance abuse counselors in Iowa completed mail-in questionnaires. **Results:** The counselors reported very little formal education regarding the needs of these clients, and nearly half had negative or ambivalent attitudes. Respondents had the greatest negativity regarding transgendered clients and reported knowing the least about this group. Counselors frequently lacked knowledge about the legal issues of these clients, the concepts of domestic partnership and internalized homophobia, and family issues. **Implications:** Substance abuse counselors require more education about LGBT clients.

Keywords: Homophobia; Attitudes; Lesbian; Gay; Bisexual; Transgender

1. Introduction

Substance abuse counselors hold considerable power and influence over their clients, and their attitudes may significantly affect clients' chances of recovery (Miller & Rollnick, 1991). Therefore, it is crucial for substance abuse counselors to understand aspects of diversity or difference in their clients and to accept each client as a unique human being rather than as stereotypes of some group. Cultural competence is rapidly becoming a core value in

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counseling fields with the recognition that treatment and prevention activities must be culturally specific to be effective.

Substance abuse counselors need to be aware of lesbian, gay, bisexual, and transgender (LGBT) issues, because research is fairly clear in showing elevated rates in LGBT people compared to the general population (Bloomfield, 1993; Hughes, 1999; McKirnan & Peterson, 1989; Skinner, 1994). This is not to say that sexual orientation and gender identity per se are causes of substance abuse. Instead, the elevated rates of substance abuse appear to be related to societal reactions to LGBT people, such as:

- the stigma associated with belonging to an often despised minority (Kettelhack, 1999);
- stress of daily living associated with this identity such as needing to hide the identity to keep a job or experiencing harassment or discrimination (McKirnan & Peterson, 1988; Rothblum, 1990);
- the significance of gay bars as a major and sometimes the only social outlet;
- finding friends in bar settings, which increase the likelihood of falling into a heavy drinking/using peer group (Weinberg, 1994);
- greater likelihood of loss of family support;
- balancing multiple roles and responsibilities (Hughes & Wilsnack, 1997);
- and nonacceptance of self (Kus, 1988) or internalized homophobia or transphobia. Internalized homophobia/transphobia refers to the acceptance of negative societal stereotypes and attitudes about LGBT people, and can result in lower self-esteem and lack of feelings of self-worth (Ghindia & Kola, 1996).

As training programs and continuing education forums are increasingly addressing the needs of diverse clients, those clients who are LGBT may be omitted or ignored for many reasons. Trainers may have limited knowledge of these issues, be afraid to present potentially controversial information, think of diversity strictly in terms of racial difference, or be uncomfortable talking about sexuality. Very little research has examined the attitudes of substance abuse counselors. Hellman, Stanton, Lee, Tytun, and Vachon (1989) surveyed 164 staff members from 36 alcohol treatment programs in New York City (64 men and 94 women). Over 80% had a college degree, but 71% reported little or no training about lesbian and gay issues. One-third of the sample reported that they never interviewed new clients about sexual orientation and only 21% of the staff routinely included information about sexuality in their interviews. About 44% thought that lesbian and gay clients had the same treatment outcomes as heterosexual clients, but a significant number (38%) thought that lesbian and gay clients had more difficulty achieving sobriety than heterosexual clients. Only 6% of the programs had special groups or programs for gay clients.

In 1988, Israelstam surveyed 85 substance abuse counselors in Ontario and found that most respondents (68%) viewed homosexuality as a learned behavior and about one-third viewed it as a behavioral disorder. The counselors in this study believed that gay men and lesbians were much more likely to be heavy drinkers and recreational drug users than their heterosexual counterparts. Nearly 30% said that they would be uncomfortable working with gay or lesbian clients. The majority agreed that sexual orientation should be taken into

account in the treatment of lesbians and gay men, but only 44% thought that special treatments were needed. The majority felt that substance abuse treatment should help them be comfortable with their sexuality (85%) rather than try to cure them of it (only 9% thought this would be valuable). Just over one-third of the respondents thought that lesbian and gay clients would be more difficult to treat than heterosexuals.

Research on attitudes regarding sexual minorities has primarily focused on lesbians and gay men, with very little research on attitudes about bisexual or transgendered people. The currently available research suggests that people with negative attitudes are more likely to be male than female, uneducated than college educated, people with fundamentalist religious beliefs than other religious traditions, and people with limited or no personal contact with lesbian or gay people than people who know lesbians or gay men personally (Eliason, 1995; Herek & Glunt, 1993; Kite & Whitley, 1996). One recent study found similar correlates for biphobia (Eliason, 1997), but there has been no published empirical research on attitudes about transgendered people. There are reasons to believe that negative attitudes about transgendered people may stem from the same underlying reasons as negative attitudes about LGB people, primarily related to deviation from societal gender roles and religious beliefs.

A few studies have examined professional group attitudes, since the beliefs of psychologists, social workers, nurses, physicians, and other health care professionals may have profound impact on the treatment that LGBT people receive (Berkman & Zinberg, 1997). For example, Mathews, Booth, Turner, and Kessler (1986) found that 37% of California physicians had favorable attitudes, 40% had neutral attitudes, and 23% had negative attitudes about gay clients/patients. A study of family practice physicians found that 36% scored in the homophobic range on an attitude scale, although only 23% admitted that they were prejudiced against gay and lesbian people (Chaimowitz, 1991). One study of medical students found that gay male patients were viewed as more responsible for their illnesses, more dangerous to others, and as experiencing less physical pain than male heterosexual patients. The medical students also rated gay male patients as more offensive, less truthful, less likeable, and inferior to heterosexual patients (Kelly, Lawrence, Smith, Hood, & Cook, 1987). There is also some evidence that LGBT people avoid seeking health care because of these attitudes (Eliason, 1996).

The purpose of this study was to determine the knowledge and attitudes of substance abuse counselors regarding LGBT clients, an area ignored in the substance abuse literature since the Hellman et al. (1989) and Israelstam (1988) studies more than 10 years ago. The current study added questions about bisexual and transgendered people.

2. Method

2.1. Sample

After approval by the institution's human subjects review board in March of 2000, questionnaires were sent to the directors of community- and hospital-based substance

abuse treatment agencies in Iowa. This includes all the agencies with block grant funding for substance abuse treatment. Since no information about the number of staff per agency was available, 20 questionnaires with stamped return envelops were sent to every address, with instructions to distribute to staff and then return any excess questionnaires. A total of 1000 questionnaires were mailed, 305 were returned as excess, and 242 were returned completed. Thus, the return rate was 35%. A cover letter to potential participants informed them of the purposes of the study, stressing that their responses would be anonymous and that returning a completed questionnaire would be considered evidence of their consent.

2.2. Measures

In order to be clear on the meanings of the terms *lesbian*, *gay*, *bisexual*, and *transgender*, the first paragraph of the questionnaire included the following definitions:

Lesbian
: a self-identified woman who has her primary sexual and emotional connections with other women.

Gay
: a self-identified man who has his primary sexual and emotional connections with other men.

Bisexual
: self-identified men or women who have sexual and emotional connections with women and men.

Transgendered
: people who do not fit into societal gender roles/expectations, including, but not limited to, people who are transsexual, transvestite, and cross-dressers. Transgendered people may be heterosexual, lesbian, gay, or bisexual in their sexual orientation.

The remainder of the questionnaire was organized into four categories: attitudes about LGBT people, experience/knowledge/familiarity with LGBT people and issues, demographic variables, and open-ended responses.

2.3. Experience/knowledge/familiarity

The items in this section asked respondents about their familiarity with each group (lesbian, gay, bisexual, transgender), how many clients the respondent had worked with in the past year who identified as LGBT, how comfortable the respondent felt around people in each category, and how familiar they were with common issues of LGBT people. These common issues were culled from a review of the literature as the most frequently mentioned items related to quality of life for LGBT people (homophobia, internalized homophobia, heterosexism, coming out, relationship issues, family issues, coping styles, legal issues, gay-bashing/hate crimes, domestic partnership laws, and substance abuse prevalence). Respondents were asked whether human rights/civil rights codes in the state of Iowa included sexual orientation or

gender identity as protected classes. The next set of questions concerned the hours of training or education on these issues in formal education and continuing education. One question asked about hours of training about LGB issues, and a separate item about training on transgender issues. The next items asked how many friends, acquaintances, or relatives they had who were LGB (one total), and how many friends, acquaintances, relatives who were transgendered.

2.4. Attitudes

An adaptation of Gregory Herek's Attitudes Toward Lesbians and Gays (ATLG) was administered. This widely used scale has excellent psychometric qualities. The short version of this survey contained five items regarding lesbians and five items regarding gay men, and was chosen to keep the administration time as brief as possible. This version had adequate psychometric qualities with an alpha coefficient of .87. It correlates with the longer scale at the .95 (lesbian items) to .96 level (gay male items) (Herek, 1994). The author of the current study added five items on bisexuality and five items on transgender in the same style and format as the ATLG items. The final scale had 20 items: five each concerning lesbians, gay men, bisexual people, and transgendered people. All of the items were rated on a nine-point scale whereby one indicated strongly disagree and nine indicated strongly agree. Coefficient alphas of the current data were calculated for the total score (.94), as well as for each separate subscale (lesbian scale=.78; gay male scale=.84; bisexual scale=.75; and transgender scale=.81), and were deemed acceptable.

2.5. Demographic variables

The final section included demographic information including age, sex, sexual orientation, size of community when growing up and now (rural area, small town, small city, large urban area), race, education, number of years as a substance abuse counselor, type of religious affiliation, job and career satisfaction. A follow-up question about religion asked, "What does your religious denomination or personal spiritual beliefs say about LGBT people?" The options were "they are sinful and immoral," "they are to be accepted as people but their behavior condemned," and "they are to be accepted completely." The final multiple choice item asked whether the respondent thought that LGBT people benefited more, less, or the same from substance abuse treatment than heterosexual people.

2.6. Open-ended items

The last two questions were open-ended and asked "What problems do you think LGBT people in substance abuse treatment programs have?" and "Any other comments related to LGBT people and substance abuse?" It appeared that most respondents collapsed these two items, so they were combined for the content analysis.

2.7. Data analysis

The data warranted both quantitative and qualitative analyses. First, descriptive analyses of the categorical and scale data were conducted to identify prevalence of negative attitudes and degree of knowledge and experience. Secondly, inferential statistics were used to determine the correlates of negative attitudes. Stepwise multiple regression models were used to determine the relative influence of demographic variables on attitudes toward each of the four groups: lesbians, gay men, bisexuals, and transgendered people. The open-ended items were independently coded by two reviewers for major themes, then discussed with a third reviewer.

3. Results

3.1. Demographic/personal information

The mean age of the sample was 41 with a range of 19–65. The respondents had worked as substance abuse counselors for an average of 7.2 years, with a range of 0–41 years. The majority (73%) were female, 26% were male, and two respondents (less than 1%) indicated that they were transgendered. The majority were heterosexual (93%), but 2.5% were self-reported lesbians, 1.2% were gay men, and 3% were bisexual. The majority were also white (93%), with 3.3% African American, 0.4% Native American, and 3% ''other'' (this corresponds with Iowa's general population, which is 97% white). In regards to religion, 57% were Protestants, 12% Catholics, 0.4% Jewish, and 25% checked ''other.''

There was a fairly high level of education reported by most of the respondents, and only 1.7% had no college education. Seven percent had some college education, 14% had an associate degree, 32% had a baccalaureate degree, 13% had some graduate education, and 32% had a graduate degree. Over one-third (36%) reported that they grew up in a rural area whereas 26% lived in a small town, 29% in a medium-sized city, and 9% grew up in an urban area. Their current living situations were similar: 22% rural, 25% small town, 48% medium-sized city, and 4% urban. Most of the respondents were satisfied with their current jobs: 52% were very satisfied, 38% were somewhat satisfied, 7% were somewhat unsatisfied, and 1% were very unsatisfied. In regards to their career choices, 69% were very satisfied, 26% were somewhat satisfied, 4.5% were somewhat unsatisfied, and 0.4% were very unsatisfied.

3.2. Experience/knowledge/familiarity

Exactly half of the sample reported that they had no instruction at all about LGB issues in their formal educational programs, and 80% had no instruction about transgender issues. Of those who had some formal education on LGB issues, 60% had 5 hours or less of instruction (mean = 4.6 h). Ninety percent (90%) of those who had some formal education regarding transgender issues reported five or fewer hours of training (mean = 0.9 h). In continuing education programs, 58% had received no training on LGB issues and 86% had

no training regarding transgender issues. Again, the majority who had received some instruction had less than 5 h (mean of 4.3 h for LGB issues, and 0.5 h on transgender issues). The vast majority of the sample reported knowing a person who was LGB (93%), but 75% did not know any transgendered person. About 10% reported knowing 20 or more LGB people, whereas only one respondent knew this many transgendered people. Fewer respondents reported that they had worked with a LGBT person in the past year. Many of the respondents reported that they worked with no lesbians (43%), gay men (40%), bisexuals (54%), or transgendered people (85%) in the past year. Only 5% reported working with five or more LGBT clients in the past year.

Table 1 depicts the responses regarding familiarity with LGBT clients and issues, and shows a considerable lack of knowledge. In general, the respondents were more familiar with issues concerning lesbians and gay men than they were with issues concerning bisexual or transgendered people. The majority of respondents reported a lack of knowledge regarding domestic partnership and other legal issues, coping strategies, the concept of internalized homophobia, and family issues. They were somewhat more familiar with the concept of homophobia (80% had some familiarity), relationship issues (77%), gay-bashing and hate crimes (74%), the prevalence of substance abuse in these groups (72%), appropriate terminology to refer to LGBT people and communities (66%), and the coming-out process (64%).

Table 1
Counselors' level of familiarity with LGBT individuals and associated issues (percents and mean scores)[a] ($N = 242$)

	Unfamiliar (%)	Mean	S.D.
Group			
Lesbians	16	3.63	0.65
Gay Men	18	3.61	0.67
Bisexuals	26	3.56	0.71
Transgendered	70	3.19	0.91
Specific issues			
Substance abuse prevalence	28	2.90	0.88
Relationship issues	23	2.9	0.79
Coming-out process	36	2.7	0.90
Gay-bashing/hate crimes	27	2.8	0.82
Domestic partnership laws	69	2.1	0.88
Legal issues, e.g., power of attorney	73	2.0	0.88
Coping strategies	47	2.5	0.90
Appropriate terminology	36	2.7	0.86
Homophobia	24	3.0	0.83
Heterosexism	42	2.6	1.0
Internalized homophobia	48	2.5	0.95
Family issues	54	2.4	0.88
Legal protection	68	2.1	0.88

[a] Scores of 1 = *not at all familiar* and 4 = *very familiar.*

The state of Iowa has no statewide legal protection for either sexual orientation or gender identity, however, only 23% of the sample knew this. One-third thought that both sexual orientation and gender identity were protected classes, 2% thought that only sexual orientation was protected, and 45% thought that only gender identity was protected.

3.3. Attitudes

When asked to report what their religious faith had to say about LGBT people, 19% reported that "they are sinful and immoral," 41% reported that "they are to be accepted as people but their behavior condemned," and 40% indicated that "they are to be accepted completely." Thirty-six respondents did not answer this question.

In order to obtain an overall picture of the respondents' attitudes, the four scales (lesbian, gay, bisexual, and transgender) were summed to form a total phobia scale. Positively worded items were reverse-scored so that in all cases, higher scores indicated more negative attitudes (these items are marked with an "R" in Table 3). The scores were divided into three equal categories: Scores of 20 to 60 were considered to indicate clearly accepting or positive attitudes, and included 56% of the sample. Scores of 61 to 139 included some positive ratings and some negative ratings, thus was labeled as "ambivalent" attitudes, and included 34% of the sample, whereas scores of 140 and higher were clearly negative (10% of the overall sample).

These scores relied on the combination of attitudes about LGBT people, therefore, if a person had more negativity toward one group than another, the score may not be very meaningful. Respondents were more negative about bisexuals (mean = 16.7, S.D. = 8.4) and transgendered people (mean = 18.4, S.D. = 10.1) than gay men (mean = 14.5, S.D. = 9.9) or lesbians (mean score of 13.4, S.D. = 8.2). However, these differences were not statistically significant. Table 2 breaks down the phobia scores by sexual identity category.

Pearson r correlations between the lesbian, gay, bisexual, transgender, and total scores were highly significant, ranging from .71 to .94 (all were significant at the $P < .001$ level, two-tailed). There were no significant differences in attitudes of female or male respondents on any of the four sexual orientation/gender groups. Although women tended to have lower scores on all four subscales, they were not significantly lower than the men's scores.

Table 3 shows the responses to the separate attitude questions regarding LGBT people. The respondents were most negative about transgendered people, followed by bisexuals, then gay

Table 2
Counselors' attitudes towards sexual/gender identity groups ($N = 242$)

Category	Positive (%)	Ambivalent (%)	Negative (%)	Mean	S.D.
Lesbians	68	28	4	13.4	8.2
Gay men	64	27	9	14.5	9.9
Bisexuals	53	38	9	16.8	8.5
Transgendered	44	43	13	18.4	10.1
Overall	56	34	10	63.3	33.7

Table 3
Counselors' responses to individual attitude statements about LGBT individuals[a]

Statement	Mean (S.D.)
Lesbians just can't fit into our society.	2.0 (1.8)
State laws regulating private, consenting lesbian behavior should be loosened [R].[b]	5.4 (2.5)
Female homosexuality is a sin.	2.8 (2.8)
Female homosexuality in itself is not a problem, but what society makes of it can be a problem [R].	5.9 (2.4)
Lesbians are sick.	1.7 (1.6)
I think male homosexuals are disgusting.	1.8 (1.7)
Male homosexuality is a perversion.	2.3 (2.3)
Just as in other species, male homosexuality is a natural expression of sexuality in man [R].	5.8 (2.9)
Homosexual behavior between two men is just plain wrong.	2.9 (2.7)
Male homosexuality is merely a different kind of lifestyle that should not be condemned [R].	5.6 (2.9)
Bisexuals are sick.	2.2 (2.1)
All people are probably born bisexual [R].	4.4 (2.5)
There is no place in the moral fabric of society for bisexuality.	2.8 (2.3)
Bisexuality is merely one of many normal variants of human sexuality [R].	6.2 (2.8)
There should be stricter laws regulating bisexual behavior.	2.3 (1.9)
Transgendered people are sick.	2.7 (2.3)
Laws that regulate people's expressions of gender should be removed [R].	5.5 (2.6)
God made man and woman: anything else is abnormal.	3.1 (2.7)
Having only two sexes is limiting: transgendered people are an expression of the continuum of gender [R].	4.1 (2.6)
It is necessary to have clear distinctions between women and men.	4.1 (2.6)

[a] Scores above 5 indicate *agreement*, whereas scores below 5 indicate *disagreement*.
[b] Scores marked with an [R] were reverse-scored when forming phobia scales.

men, and were the least negative about lesbians; however, the mean scores for all four groups were relatively low, suggesting a fairly high level of tolerance and/or acceptance.

3.4. Correlates of negative attitudes

Next, a series of stepwise multiple regression analyses were conducted to determine which demographic variables might be associated with negative attitudes. Analyses were conducted separately for attitudes about lesbians, gay men, bisexuals, and transgendered people. For attitudes about lesbians, the only correlate of negative attitudes was religious beliefs about LGBT with people believing that same-sex relations are sinful or immoral having the most

negative attitudes (accounting for 30% of the variance, $F = 16.6$, $df = 180$, $P < .001$). For gay men, a combination of religious beliefs and type of religion were associated with negative attitudes, with Catholics having the most negative attitudes (these two variables accounted for 34% of the variance). For attitudes about bisexual people, four demographic variables were associated with negative attitudes: religious beliefs, sexual identity (heterosexual), career satisfaction, and education, and accounted for 40% of the variance. Finally, negative attitudes about transgendered people were associated with religious beliefs, educational level, type of religion, and sexual identity (heterosexual). These four variables accounted for 42% of the variance in the scores regarding attitudes toward transgendered people.

Since religious beliefs were a factor in the negative attitudes toward all four groups, they were examined more closely. Table 4 shows the mean attitude scores for each sex/gender identity group based on which of the three religious ideologies the respondent endorsed. In all four cases, there is no significant difference in attitude scores between believing that homosexuality is sinful and immoral and believing the "love the sinner, hate the sin" viewpoint. However, there was a significant difference between the former two views and the complete acceptance viewpoint ($P < .001$).

3.5. Qualitative analyses

Responses to the two open-ended questions were transcribed and analyzed independently by the author and a trained research assistant, and then the themes were compared and reviewed by a third independent reviewer. Because many of the comments lacked context or were sufficiently ambiguous, no attempt was made to rate the comments as negative or positive, but rather, they were grouped into common themes that might relate to treatment issues. There were 330 different comments made by the 159 respondents who completed these open-ended questions (many respondents made more than one comment). Some of the most common are described below followed by verbatim examples of respondent comments. The major themes included:

- Prejudice or discrimination within the treatment system — clients, staff, or AA meetings/mentors (27% of the comments)
  - Rejection from narrow-minded group members

Table 4
Counselors' attitudes towards LGBT individuals by three variations of religious beliefs: mean scores for each sexual/gender identity group[a]

Belief	Lesbians	Gay men	Bisexuals	Transgendered
LGBT people are sinful and immoral	15.9	17.5	18.1	22.4
"Love the sinner, hate the sin"	16.0	18.4	20.6	22.0
Acceptance of LGBT people and their behavior	10.6	10.2	13.0	14.2

[a] Higher scores indicate more negative attitudes.

- Being accepted by fellow group members as having an addiction regardless of sexual orientation
- Despite ethical obligations, therapists still have unresolved issues themselves
- Dealing with other clients who are homophobic
- Finding AA meetings that are respectful of sexuality
- In rural communities, the people from low-income homes who are in substance abuse treatment are also those who are sexually close-minded

- Lack of acceptance or not fitting into the treatment climate (17%)
  - Acceptance; finding a counselor with whom they are comfortable
  - Lack of knowledge or acceptance among staff persons
  - Believing no one else would understand what they have to deal with

- Experiences of fear and apprehension (9%)
  - Fear of discussing sensitive issues in group sessions then being viewed as resistant to treatment with a possible diagnosis of noncompliance. Fear that they may be "outed" outside of treatment by other clients
  - Fear of rejection and ridicule
  - Fear about others judging their sexuality
  - Fear of being stuck in treatment for 3 weeks with people who are homophobic

- LGBT clients are not as likely to be open or honest with counselors or in groups (9%)
  - They have more problems when they voice or declare their sexual preference
  - Being afraid to talk about specific issues for fear of what others may think
  - If they are not open about their LGBT status they can be victims of prejudice; if they are open they can also be victims of prejudice
  - Their "secret" exists in a format where being open and honest is highly valued
  - I guess I don't understand why they need to tell. Heterosexual people don't.

- LGBT clients are more likely to experience shame, guilt, and low self-esteem (8%)
  - Self-acceptance, shame/guilt, stress
  - Self-esteem, self-acceptance issues can be catalyst for substance abuse, external filler for internal void
  - LGBT quite often use substances to mask their overwhelming feelings of being abnormal
  - Self-loathing as a result of social mores
  - All LGBT patients we have had have been abuse victims (sexual and physical) and so have multiple issues to deal with

- LGBT clients lack social support for sobriety (5%)
  - Some difficulty acquiring solid, sober, social support
  - Finding a sober peer group
  - Not enough recovering peers to relate to

- When a hetero "dries out" it is relatively easy to find new playmates and playgrounds. When a LGBT person "dries out" there may be no other playmates or playgrounds
- Finding places to socialize that aren't gay bars

- LGBT clients, if out, may monopolize the treatment setting (4%).
  - When identified as LGBT that may be the focus of other group members — this can cause less positive outcomes for all.
  - More time can get spend on addressing homophobia in the treatment community than on the substance abuser's need.
  - Not making LGBT a bigger issue than it needs to be and not addressing others of importance
  - The patient focuses exclusively on their sexuality issues to the exclusion of focusing on their addiction
  - Wanting to be treated differently/uniquely, focus on their differences
  - In group settings peers are very critical and discriminatory of LGBT people in order to take the focus off their own addiction and themselves

Several of the respondent comments suggested potential conflicts between counselor viewpoints and client recovery. For example, "they don't want to look at their gender preference as a result of a gene imbalance" implies that we know the biological underpinnings of gender and/or sexuality and that it is due to "imbalance" or disorder. The truth is, there is no clear biological explanation for the diversity of gender and sexual expression in our culture (Bohan, 1996). Another respondent noted, "Since it is generally politically correct to unconditionally accept the client's sexual choice, I believe we often ignore or overlook emotional issues that may be contributing directly to the client's substance abuse. The shame, guilt, inability to cope with society, and not being able to reconcile with God, not having repented the sin ... Christian based treatment programs have 65–95% success rates, so until we change our approach to embrace a biblical sin based treatment regime, we never truly change people's lifestyles, we are simply applying band-aids to cut juglar [sic] veins." The LGBT client of this counselor stands to receive an extremely shame-based approach to treatment assuming that sexual orientation is the problem, rather than addiction.

4. Discussion

The results of the study must be reviewed with caution because all the respondents were drawn from one rural state and the response rate was low. The respondents were similar to substance abuse counselors in the state as a whole on all but one characteristic — education. The fact that this group was more highly educated than expected might led to speculations that the results will underestimate the frequency of negative attitudes since considerable research has identified higher education to be associated with more positive attitudes.

This study suggested that as a whole, substance abuse counselors lack knowledge about LGBT people's issues, but many have tolerant or accepting attitudes. However, the 44% of the sample with distinctly negative or ambivalent attitudes may influence an entire agency. Counselors with negative attitudes may view sexual orientation rather than the addiction as the problem (Israelstam & Lambert, 1986) or they may attempt to treat LGBT clients the same way as heterosexual clients, rendering the sexual orientation and societal stigma invisible and unacknowledged. Review of the open-ended comments suggested that some of the respondents thought that LGBT issues should be ignored, or that they were made too much of in treatment. One respondent suggested that counselors should "not make LGBT a bigger issue than it needs to be" whereas another said, "spending a great deal of time as a self-enlisted spokesperson for the LGBT population immediately alienates all involved." Yet another counselor reported, "Their problems are no different than a heterosexual. I do feel as if this group is held up and they take the victim stance approach." These comments represent an ethical dilemma for substance abuse counselors. Do they address the needs of LGBT clients in groups, if that means tackling the prejudices of other group members, or do they ignore the needs of the LGBT individual to focus on needs more closely related to the substance abuse problems of the entire group?

In this study, demographic variables were largely uninformative in predicting which substance abuse counselors might have negative attitudes. Unlike other studies, men were not more negative than women. This may be due to the nature of the attitude questions and the context of the survey that set up an expectation of treatment and civil rights issues rather than personal feelings. Kite and Whitley (1996) found that men were more negative about gay men on a personal level, but did not differ from women on attitudes about lesbians, or on civil rights issues regarding homosexuality. However, religious beliefs were a significant factor in negative attitudes in this study, and counselors who reported believing that LGBT people are sinful or immoral, or who expressed the view of "love the sinner, hate the sin" also reported much more negative attitudes about LGBT clients than counselors who stated that their religions or personal religious beliefs are accepting of all people. As one respondent stated, "the AA approach is very religious and could be seen as homophobic — the Big Book certainly does not have any examples of LGBT folks." In treatment settings where religion and policy/treatment issues are supposed to be separate, discussions about the negative impact of these religious beliefs must take place.

Respondents in this study had some familiarity with "homophobia," a term that refers to negative attitudes about people who are LGB, however, they were not very familiar with the term "internalized homophobia" (48% were unfamiliar with it). Many experts suggest that LGB people assimilate societal negative stereotypes to some extent, and if not countered by positive role models or accurate information, it can lead to feelings of low self-worth, shame, and guilt (Allen & Oleson, 1999; Shidlo, 1994). Some LGBT people cope with negative emotions by self-medicating with alcohol or drugs, therefore, it is crucial that substance abuse counselors assess LGBT clients for internalized homophobia and incorporate these issues into the treatment process as needed. It might be helpful for substance abuse counselors to learn about some of the "coming-out" models in the psychological literature that describe some of the stages or psychological states that an LGBT person might experience. For example, identity confusion is a common early stage, when the person only knows negative stereotypes

about LGBT persons and is striving to understand where he/she fits into this identity. Fears about rejection from family or friends, or fears of loss of job, family, or children are prevalent at this stage and may lead to increased alcohol and drug use. Later stages of immersion into gay culture may also be fraught with risk for substance abuse if the major form of social activity in the community is the gay bar. For others who have dealt with identity issues and have accepted or embraced their sexuality, the stresses of developing stable relationships or experiences of workplace discrimination may be the major problems. For more information on coming-out models, see Cass (1984), Eliason (1996), Plummer (1975), Rust (1993), or Troiden (1988). Less is known about the identity development of transgender people, but it very well may be even more difficult than achieving sexual identity.

A significant number of respondents (42%) were unfamiliar with the concept of heterosexism. This term refers to the lack of acknowledgement and often invisibility of same-sex relationships or orientations in our society. Books in school libraries rarely depict same-sex parents or gay youth; television, movies, and books often portray negative stereotypes of LGBT people or they are absent entirely; the legal system denies marriage to same-sex couples; and some fundamentalist religions use their war against homosexuality as a fund-raising ploy. The rendering of one's life as invisible or less than that of a heterosexual person can have devastating effects on mental health and well-being and contribute to substance abuse. If this invisibility extends to substance abuse treatment, treatment outcomes are compromised. Being treated like everyone else is often a detriment to recovery for clients from all minority groups (Center for Substance Abuse Treatment, 1999), because equal treatment generally means being placed in a program designed for and by white, heterosexual, middle class men.

Nearly three-quarters of substance abuse counselors were unfamiliar with the legal issues of their LGBT clients. Since same-sex couples cannot legally marry, many other forms of legal protection are necessary to protect relationships. For example, many same-sex couples have power of attorney for health care and finances so that in the event that one partner is incapacitated, the other has legal authority to make medical and financial decisions. Without power of attorney for health care, the partner may be left out of decision-making and denied visitation of the loved one. Wills are necessary to protect the property rights of same-sex couples. A few cities and large businesses in the US have domestic partner policies that provide health insurance, life insurance, and other benefits to same-sex partners who meet the requirements. Nearly 70% of the substance abuse counselors in this study were unfamiliar with the concept of domestic partnership. It is important that counselors be aware of domestic partnership policies in their own cities and localities. In addition, it is important to know if sexual orientation or gender identity is protected by the human rights codes of the city or state.

Legal issues for transgendered people can be even more complicated, particularly for people in transition (living as the sex other than their physical bodies). They may need to carry a letter from their physician or psychologist explaining why their driver's license, passport, or other document lists one sex while they appear to be the other. Only after gender reassignment surgery (which only a few can complete because of the expense), can a person legally change their driver's license, birth certificate, passport, and other legal documents to be congruent with their appearance. The requirements for changing legal documents vary from state to state. Issues for transgendered clients in substance abuse treatment programs

may stem from questions about roommate assignment, bathroom and shower use, and whether to assign to gender-specific groups. For example, a few years ago in California, a preoperative male-to-female person disclosed her identity to a school before enrolling and was assigned to a woman's dormitory. Later, the university insisted that she reveal her identity to the other dorm residents (that is, tell them she had a penis), or be evicted. She informed her dorm mates and obtained the written consent of every member of the dorm to remain there but still had to engage in a legal battle with university administration to avoid being placed in a male dorm where she would have experienced considerable harassment and maybe even violence (Ettner, 1999). For practical information regarding the legal and medical issues of the transsexual client, see Israel and Tarver (1997) and Kirk and Rothblatt (1995). People in transition may be taking hormones, and need to be allowed to continue hormone therapies while in treatment. Although they might be construed as "mood-altering" drugs, they are necessary and safe if used as prescribed. Issues for clients who are transgendered, but not considering medical or surgical interventions are more complex and need to be addressed on an individual basis (Leslie, Perina, & Maqueda, 2001).

Nearly half of the sample were unfamiliar with the coping strategies used to manage sexual orientation/identity issues. These are important in developing a relapse prevention plan. There are many forms of "identity management" that LGBT persons may use. For example, some lead double lives, being "gay" or transgendered at home, but "straight" or gendered at work or within families. Double lives require considerable effort to hide a significant part of one's life from others. However, even those who are "out" or open about their sexuality or gender have to face daily experiences of being different. Both the closet and the open life are stressful and may contribute to substance abuse. It is important for substance abuse counselors to assess the coping methods of LGBT clients and help them identify healthy methods to replace the use of alcohol or drugs as coping mechanisms.

Over half of the sample was unfamiliar with the family issues that face many LGBT clients. There are issues with both families of origin and families of choice (Weston, 1991). "Coming-out" or revealing one's sexual or gender orientation to others can be traumatic in many families of origin. LGBT people face possible rejection from the very people who are supposed to offer unconditional love and support. They often form strong emotional bonds with peers to replace the lost family support. Families of choice can include these strong kinship bonds as well as sexual/romantic partners. Many LGBT people have children from previous or current heterosexual relationships, from adoption, co-parenting of a partner's children, or by artificial insemination or surrogate mothers. Family members, however, defined by the individual, must be included in the treatment process.

In conclusion, substance abuse counselors have considerable influence over their client's recovery process and tailoring treatment to meet the client's unique needs is more likely to lead to success than attempting to fit the client into existing treatment modes. It is clear that there needs to be better education about the potential needs of LGBT clients in substance abuse training programs and continuing education programs. In the words of one respondent, "Treatment is usually a microcosm of society. They [LGBT clients] feel or ride the same disapproval they might always encounter. In treatment, though, one is so vulnerable that disapproval by the group can interfere or prevent recovery. It is imperative that counselors

grasp that." Appendix A lists some resources for substance abuse counselors who wish to expand their knowledge base about LGBT clients.

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Appendix A. Informational Resources for Substance Abuse Counselors

General information about LGBT people

Eliason, M. J (1996). *Who cares? Institutional barriers to health care for lesbian, gay, and bisexual people.* New York: National League for Nursing Press.

Greene, B. (1997). *Ethnic and cultural diversity among lesbians and gay men.* Thousand Oaks, CA: Sage.

Israel, G. E., & Tarver, D. E. (1997). *Transgender care: recommended guidelines, practical information, and personal accounts.* Philadelphia, PA: Temple Univ. Press.

Substance abuse prevalence, epidemiology, treatment

Center for Substance Abuse Treatment (2001). *A providers guide to substance abuse treatment for lesbian, gay, bisexual, and transgender individuals.*

Kettelhack, G. (1999). *Vastly more than that: stories of lesbians and gay men in recovery.* Center City, MN: Hazelden.

Kus, R. J. (1995). *Addiction and recovery in gay and lesbian persons.* New York: Harrington Park Press.

New York State Office of Alcoholism and Substance Abuse Services. *Working with lesbian, gay, bisexual and transgender clients in alcoholism and substance abuse services*. New York: New York State Office of Alcoholism and Substance Abuse Services.

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Herek, G. M., & Glunt, E. K. (1993). Interpersonal contact and heterosexuals' attitudes toward gay men: results from a national survey. *Journal of Sex Research*, *30*, 239–244.

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